MEDICAL EXAMINER'S CERTIFICATE

I certify I have examined: _____ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when:

- ☐ Wearing corrective lenses
- ☐ Wearing a hearing aid
- ☐ Accompanied by a _____ waiver/exemption
- ☐ Driving with an exempt intercity zone (49 CFR 391.62)
- ☐ Accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ Qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER	DATE OF MEDICAL CERTIFICATION	DOT MEDICAL CERTIFICATE EXPIRATION DATE
(X)		

MEDICAL EXAMINER'S PRINTED NAME

☐ MD ☐ DO ☐ PA ☐ DC ☐ APN ☐ _____

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NUMBER AND ISSUING STATE	NATIONAL REGISTRY NO.	MEDICAL EXAMINER'S TELEPHONE NO.

DRIVER'S LICENSE NO. AND ISSUING STATE	IS THIS A CDL?	INTRASTATE ONLY?	SIGNATURE OF DRIVER
	☐ YES ☐ NO	☐ YES ☐ NO	**(X)**

ADDRESS OF DRIVER	DRIVER'S PHONE NO.

REVISED ON 06/14

THIS CARD IS NOT FOR RESALE.